

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-039145th 9/08/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 446277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2012
NAME OF PROVIDER OR SUPPLIER MCMINN MEMORIAL NURSING HOME & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 886 HWY 411 NORTH ETOWAH, TN 37331		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, review of the Geriatric Medication Handbook, and interview, the facility failed to meet professional standards of quality by one nurse of five nurses, on one medication cart of five medication carts, for one resident of eight residents observed on the medication pass.</p> <p>The findings included:</p> <p>Resident A was admitted to the facility on January 19, 2006, with diagnoses including Pneumonia, Dementia, Anoxic Brain Damage, and Wheezing. Medical record review of the June 2012, Recaptulation orders for Resident A, revealed the following orders: "...CLONAZEPAM 0.5MG TABLET...1 TAB (Tablet)...PER PEG TUBE THREE TIMES DAILY...GABAPENTIN 250MG/5ML SOLUTION...2 MLS (100 MG) PER PEG TUBE FOUR TIMES DAILY..."</p> <p>Observation on July 23, 2012, at 10:10 a.m., at the B Wing North #2 Medication Cart, revealed Registered Nurse (RN #1) placed one dose each of Gabapentin (medication for seizures) 100 milligram (mg) per 2 milliliters (ml) Solution and Clonazepam (medication for seizures) 0.5 mg tablet in a medication cup and dissolved both medications in 40 mls of water.</p>	F 281	This POC is being submitted in compliance with federal regulations and SOM. It is not intended to be used as an admission or for any other purpose other than the purpose stated herein.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

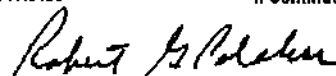
(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Robert Polshar

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F 281	<p>Continued From page 1</p> <p>Further observation at Resident A's bedside, revealed RN #1 inserted 20 mls of air into the Percutaneous Endoscopic Gastronomy (PEG) tube with a syringe and used a stethoscope to listen for sounds in the stomach to assure the tube was placed properly, opened, and medications could be administered.</p> <p>Continued observation, revealed RN #1 administered the following into the PEG tube through a syringe: 60 mls of water; the solution containing the two medications; and 60 mls of water.</p> <p>Review of the Geriatric Medication Handbook Tenth Edition, "Enteral (PEG) Tube Medication Administration" (64), revealed, "...8. Check for proper tube placement 9. Check gastric content for residual feeding...Pour dissolved/diluted medication in syringe and unclamp tubing, allowing medication to flow by gravity..."</p> <p>Review of facility policy, Feeding Tube - Instilling Medication, revealed "...a. Check placement and patency (the state of being open) by auscultation (listening for sounds). b. Check residual (food from a previous feeding left in the stomach) once daily and as needed...Insert medication by syringe slowly into tube..."</p> <p>Interview with RN #1 on July 23, 2012, at 10:35 a.m., at the B Wing North #2 Medication Cart, confirmed RN #1 did not check the residual for Resident A between checking the PEG tube placement and administering the medications, and "only checks for residual once daily."</p> <p>Interview with the Director of Nursing (DON) on</p>	F 281	<p>1. The resident will have residual checks prior to instillation of medications. There was no known harm to the resident affected by this practice</p> <p>2. Any resident receiving enteral feedings has the potential to be affected by this practice.</p> <p>3. The nursing staff was in-serviced by the DON on August 2nd and 3rd, 2012, regarding the policy and procedure for instillation of medications through a gastrostomy tube. Specific physician orders will be obtained when deviating from the policy.</p> <p>4. The DON or her designee will conduct nonscheduled medication pass observations to ensure compliance. This will be reported by the DON quarterly at the QA/PI meetings. The PI/QA committee is composed of the medical director, DON, ADON, dietitian, audit nurses, and the nursing home administrator. The consultant pharmacist will conduct random medication pass audits monthly during visits.</p>	8/3/2012	



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F 281	Continued From page 2 July 24, 2012, at 2:10 p.m., in the DON's office, confirmed the residual "needed" to be checked before the administration of medications through a PEG tube, and RN #1 had failed to follow the facility policy or meet professional standards.	F 281			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431			

Robert B. Polcher

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F 431	<p>Continued From page 3 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to provide one narcotic emergency medication of eighteen narcotic emergency medications available in one emergency box of two emergency boxes observed.</p> <p>The findings included:</p> <p>Observation of the list of contents on the outside of the Black Narcotic Emergency Box #68 on July 23, 2012, at 1:30 p.m., in the Main Medication Room on the A Wing Nursing Station, with Licensed Practical Nurse (LPN) #1 and LPN #2, revealed the box contained two, Diazepam (medication for anxiety and seizures) 10 milligram (mg) per 2 milliliters (ml) injections. Further observation during an audit of the contents revealed one, Diazepam 10 mg injection was available for emergency use.</p> <p>Review of facility policy, Narcotic ER (Emergency) Box, revealed "...Each box will contain the following medications...#2 Diazepam 10mg carpulets [injections]..."</p> <p>Interview with LPN #1 and LPN #2 on July 23, 2012, at 2:10 p.m. in the Main Medication Room, on the A Wing Nursing Station, confirmed one, Diazepam 10 mg injection was missing from the Black Narcotic Emergency Box #68.</p>	F 431	<p>1. There were no residents that were affected by this practice.</p> <p>2. Any resident for whom the missing medication was ordered would have been affected by not having the dose readily available.</p> <p>3. The supplying pharmacy was notified of the deficient practice and will post any deviation to the content list on the outside of the E - kit to alert the nursing staff that an omission exists in the locked box. (The pharmacy states this omission is due to a nationwide shortage). The nursing staff was in-serviced on August 2nd and 3rd, 2012 to notify the DON of any further deficient pharmacy practices regarding E - kits.</p> <p>4. The consultant pharmacist will do random E - kit observations upon their monthly visits with the DON or her designee. Compliance will be reported by the DON quarterly at the QA/PI meetings. The PI/QA committee is composed of the medical director, DON, ADON, dietitian, audit nurses, and the nursing home administrator.</p>	8/3/2012	

